Texas Health Care

Colon & Rectal Surgery
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1. Acknowledgment of Review of Notice of Privacy Practices

Texas Health Care, PLLC (THC) and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area and have provided a copy of the notice in your new patient paperwork. You are not required to read this notice. However, we would like your acknowledgment that you have been advised that THC has such a Notice of Privacy Practices. By signing below, you attest that you have been given the opportunity to review this notice.

2. Release of Patient Information

I consent and authorize the release of any medical records, normal or abnormal test results, lab results, hepatitis results and/or HIV results, and mental health/chemical dependency records to the following person(s):

☐ Myself
☐ My spouse: _____
☐ My child(ren): _____
☐ My primary care physician: _____
☐ My other physician(s): _____
☐ Voice mail
☐ My parent(s): _____
☐ Dr. West, Dr. Hooker, Dr. Castillo, Dr. Gordon

3. Insurance and Billing

I hereby assign, transfer, and set over to Texas Health Care, PLLC (THC), all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If a procedure/surgery is indicated, I am responsible for paying any applicable deposit prior to the procedure/surgery.

_____ _____
Signature of Patient or Personal Representative Print Name of Signed

_____ _____ / _____ / _____
Name of Patient (if different from above) Date

Patient's Date of Birth (M/D/Y): _____ / _____ / _____

Patient's Social Security Number: _____ - _____ - _____